Time-Out, Seclusion, and Restraint in Indiana Schools Literature Review

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Time-Out, Seclusion, and Restraint in Indiana Public Schools
A Literature Review

This literature review was undertaken as part of a study commissioned by the Indiana Protection and Advocacy Services (IPAS) to assess the existence of formal policy and procedures regarding the use of seclusion and restraint (and the related use of "time-outs") in Indiana school systems. The purpose of this review is to provide a context for the use of the study's findings and to identify current issues and contemporary practices.

HISTORICAL BACKGROUND

Over the past two centuries in the United States, there have been significant changes in societal attitudes toward some disenfranchised segments of the population. These changes (including new legal protections) have generally occurred *after* a particular group has taken a stand, with their allies, to assert their rights (e.g., the abolition of slavery, women gaining the right to vote, the civil rights movement, and passage of the Individuals with Disabilities Education Act). However, for some disenfranchised citizens, serious problems have endured. One such enduring problem has been the use of seclusion and restraint procedures with individuals with mental or emotional disabilities who struggle with difficult-to-manage behaviors in various settings, including schools. This group is comprised of some of the most vulnerable members of our society, who are at the same time among the least able to advocate for their own rights.

The use of seclusion and restraint with people with disabilities has always been a contentiously debated practice—certainly, at least, since the establishment of European and American mental institutions and psychiatric professional organizations (Conolly, 1856; Ozarin, 2005). While there is continued debate about the efficacy of these procedures (Day, 2002), policies and practices related to the use of seclusion and restraint have changed a great deal, especially over the last decade or so. Progress has been made toward the elimination of non-emergency seclusion and restraint, but it has not been made at the same pace across various domains. For example, policy regarding the use of these measures in educational settings has lagged behind developments in mental health settings.

DEFINITIONS

Let us begin by defining the terms "seclusion," "restraint," and the related term, "time-out." For the purposes of this review, the definitions of seclusion and restraint will be those given by The Centers for Medicare and Medicaid Services (CMS) in the Code of Federal Regulations (CFR), as they appear to be the definitions most frequently cited in the literature on this topic and have been significant in shaping policy related to these practices.

- "Restraint" is defined as "any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely" (42 CFR §482.13 (e)(1)(i)(A)). Included in the CMS definition of restraint is "chemical restraint," which refers to the use of medications that

are not part of a patient's "standard treatment or dosage" and are used as "a restriction to manage the patient's behavior or restrict the patient's freedom of movement" (42 CFR §482.13 (e) (1)(i)(B)).

- "Seclusion" is defined as "involuntary confinement of a patient in alone in a room or area from which the patient is physically prevented from leaving" (42 CFR §482.13 (e)(1)(ii)).

- CMS does not offer a definition of "time-out."

The term "time-out" has been used in a variety of other settings to describe a range of procedures that involve the removal of individuals from their peers either partially or entirely (Ryan, Peterson, & Rozalski, 2007). It was originally defined as the removal of an individual from positive reinforcement for the purposes of reducing or extinguishing a particular problematic behavior (DiLorenzo & Ollendick, 1986). This definition belies the term's roots in behavioral psychology, where it has been considered a form of "punishment" for use in behavioral modification. Ryan, Peterson, & Rozalski (2007) identified four categories of time-out: "inclusion time-out, exclusion time-out, seclusion time-out, and restrained time-out." Since seclusion time-out and restrained time-out fall under our definitions of seclusion and restraint, time-out will be defined, for our purposes, as the removal of an individual from peers or rewarding situations without the use of restraint or seclusion.

While the focus of this review is on educational policy, we can see from the attempt to define our terms that the discourse on seclusion and restraint has largely been shaped by developments in the field of mental health and practices with inpatient populations. The use of seclusion and restraint with young people with disabilities in educational settings would require the convergence of knowledge, practices, and policies from the realms of mental health *and* special education (among others). These are domains that have not been explicitly linked in the past. Changes in these fields have proceeded on related, but separate, tracks (Amos, 2004). The evolution of knowledge and policies in one domain has not translated into corresponding changes in the other, leaving individuals with disabilities in school settings "in the lurch" with regards to their protection from unnecessary or inappropriate "aversive" interventions.

MENTAL HEALTH POLICY EVOLUTION

Let us briefly review the evolution of research, practices, and public policy over the last two decades or so regarding the use of seclusion and restraint. Most of the literature has come from the mental health field, where changes have evolved more rapidly. As debates about the use of seclusion and restraint began to heat up in the 1980's and 1990's, researchers began to call into question studies that had supported the efficacy of the practices (Scotti, Evans, Meyer, & Walker, 1991; Singh, Singh, Davis, Latham, & Ayers, 1999). Re-examination of the practices by researchers found that seclusion and restraint were physically dangerous, and even life-threatening (Mohr, Petti, & Mohr, 2003; Nunno, Holden, & Tollar, 2006); were dangerous for staff members (Carmel & Hunt, 1989); were not ultimately effective in producing behavioral change (Atkins & Ricciuti, 1992); and, that they resulted in significant psychological trauma for all those involved (Bonner, Lowe, Rawcliffe, & Wellman, 2002). They also found that the use of seclusion and restraint was inconsistent and highly variable between sites (Betemps, Somoza, &

Buncher, 1993). It was not governed so much by the needs of patients, as by arbitrary decisions and qualitative differences in the staff involved (Goren & Curtis, 1996). However, early reform efforts did not aim to eliminate the practices; rather, they seem to have been aimed at making the practices safer or more humane (Amos, 2004). The use of seclusion and restraint was a deeply entrenched part of institutional culture, and was viewed as an unfortunate, but necessary evil. Change in practice required change in culture (Smith, et al., 2005). This meant that change efforts would need to be made at a systemic level, requiring the creation of public policy.

The beginning of more substantive reforms in the field of mental health has been widely attributed to the publication of an investigative report that appeared in the Hartford Courant in 1998 (Weiss, Altimari, Blint, & Megan, 1998). This report, entitled "Deadly Restraint: A Nationwide Pattern of Death," documented 142 deaths resulting from the use of seclusion and restraint procedures with individuals in institutional settings between 1988 and 1998, a disproportionate number of whom were children and adolescents. Public outcry stemming from the publication of this investigative series resulted in Congressional action. The General Accounting Office (GAO), a federal investigative agency, was directed to collect data on institutional practices, review relevant research, make policy recommendations, and report their findings to Congress. Part of the problem in the field of mental health at that time was that seclusion and restraint occurred in a kind of "black box," without oversight or regular documentation (General Accounting Office, 1999). This is the situation that appears to exist for many people subjected to these procedures in school settings today. A number of papers reviewed for this report point to the need for research to collect data and throw a light on what is actually occurring in schools.

At the time of the GAO investigation, some states had already begun to explore the possibility of reducing or eliminating the practices of seclusion and restraint in mental health settings. One notable example came from Pennsylvania, where hospital reforms resulted in dramatic decreases—virtually eliminating the practices in some sites, and improving the institutional environment for both staff members and the people they cared for (Hardestine, 2001). This and other examples influenced the recommendations for policy changes made at the federal level, which endorsed prevention through mandatory data collection and reporting, oversight by physicians, time limits on seclusions, regular training of staff, etc, (GAO, 1999). A potential problem with the federal policy was that it might simply have remained as a guideline, and states would have been left entirely to their own devices in terms of implementation. This would have resulted in very uneven progress towards substantive change nationwide—a patchwork of widely varying protections from state to state. The prospects for change improved with the decision to tie compliance with federal guidelines to funding by Medicare and Medicaid and to accreditation of care facilities by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). With the addition of these "teeth" to policies on non-emergency seclusion and restraint, mental healthcare facilities began making serious efforts to examine their practices and work toward eliminating these dangerous procedures.

POLICY EVOLUTION IN SCHOOL SETTINGS

These changes in mental health were significant, and have had an impact on the lives of many in the mental health care system. However, only a small percentage of the people who are potentially subject to these practices are protected by the changes, as most of them are not directly involved in the mental health care system (Gross, 2003). Of particular significance is the fact that these policies and protections did not apply to the field of education. The Children's Health Act (CHA) of 2000 mandated the elimination of non-emergency seclusion and restraint in facilities that serve children and receive federal funds, but did not apply to schools. A number of advocacy groups today are striving to eliminate the use of seclusion and restraint in all settings.

To understand how seclusion and restraint have become issues in school settings, we need to look back to the enactment of the Individuals with Disabilities Education Act (IDEA). With the enactment of IDEA, children and adolescents with various disabilities, who had been excluded from mainstream educational opportunities in the past, were given access to the resources available to other students in public schools. This transition has not been without problems, though, as educators and education policymakers have had to learn how to appropriately provide for the special needs of these students, including the challenging behavioral issues that some of these students struggle with. With the arrival of this new student population in public schools came many of the attitudes and practices they had been subjected to in settings without "educational" aims. In other words, the "behavior management" culture, from settings more concerned with reaching behavioral benchmarks than with addressing educational and quality of life issues for individuals with disabilities (Carr, et al., 2002), was largely transposed onto public school settings. Disturbing and morally repugnant "aversive" practices, derived from some behavioral approaches and ostensibly used with the goal of behavior change, have been justified in terms of their theoretical bases and alleged efficacy (Amos, 2004). Interestingly, progressive alternatives to these draconian methods (to be discussed below) still claim behavioral psychology as a principle influence, but are careful to note the integration of person-centered, humanistic values into their theoretical frameworks (Carr, et al., 2002).

Research in the field of mental health demonstrated that the practices of seclusion and restraint, as well as other "aversive" behavioral strategies, were dangerous. It also raised concerns about the practices possibly being iatrogenic, (causing the problems they were meant to eliminate), (Cohen-Cole, 2002; Amos, 2004). While this led to changes in policy and practice in mental health facilities, as pointed out earlier, practices and attitudes concerning individuals in educational settings have been slower to evolve. In terms of seclusion and restraint use in schools, research has been sparse and contradictory (Amos, 2004; Ryan, Peterson, & Rozalski, 2007), but appears to generally confirm that the procedures are dangerous and of questionable effectiveness, particularly in the context of promoting educational aims. Research has also pointed out that seclusion, restraint, and time-outs are often used as matters of convenience or as punitive measures with no aim toward lasting behavior change, and in the case of time-outs, without consideration of the positive reinforcements that should exist *a priori* (Delaney, 1999). Even the behavioral literature of decades past explicitly states that "punishment" cannot produce behavior change if it is not accompanied by teaching and "reinforcement" of more desirable behaviors (DiLorenzo & Ollendick, 1986). An emphasis on teaching desirable behaviors can be

found in a very powerful model for change that comes, once again, from Pennsylvania.

Positive Behavior Support

Centennial School, in Bethlehem, Pennsylvania, is a private school affiliated with Lehigh University. Students with serious emotional, behavioral, and developmental disabilities are referred there from area school districts that feel they are unable to appropriately address the behavioral problems or special needs of these students. In the late 1990's, Centennial School undertook needed reforms aimed at improving the school's climate and chose to use the number of seclusion and restraint incidents as a measure of whether or not their reforms were succeeding. Prior to these reform efforts, Centennial School had a large number of restraint incidents per year (1,064 during the 1997-1998 school year), and did not even document the widespread use of seclusion, or exclusionary time-out, as the practice was endemic. Staff injury and assaults against teachers were not uncommon either(Miller, George, & Fogt, 2005).

Miller et al (2005) assert that effecting change at Centennial School required systemic change—a change of the school's culture. This required the careful examination of implicit beliefs held by those charged with educating and caring for these students. Students were essentially meeting the expectations of staff members, who believed their students were incapable of completing homework, could not control their behaviors (and therefore, could not be held accountable for them), and had very limited capacity for change and growth. New leadership (a new director) initiated staff reflection on the relationship between these beliefs and the problematic conditions in the school. Collectively, the staff of Centennial School created a new set of goals and guiding principles for the school. Their new mission statement put forward the goal of creating "a place where students, staff, and parents want to be, and where they can learn new skills that would benefit them now and in the future." To this end, they set out to: "(1) develop an enriched and stimulating curriculum; (2) create a safe, civil learning environment; and (3) establish greater partnerships with parents." In order to facilitate the goal of a "safe, civil learning environment," they decided to implement a school-wide, research-based, program of effective (or "positive") behavioral support (Miller, George, & Fogt, 2005).

Positive Behavioral Support (PBS) is an empirically-supported approach to addressing behavior issues in schools that seeks to uncover the causes of problem behaviors by examining their contextual antecedents (Washburn, Stowe, Cole, & Robinson, 2007). It is proactive, in that it emphasizes creating environments and practices that promote desirable behaviors (effectively preventing problem behaviors), rather than focusing on retroactively reacting to problem behaviors. Put another way, the aim is to systematically look for the causes of problem behaviors, and preemptively assist students in acquiring better ways to meet their needs.

It also incorporates different levels, or "tiers" of intervention. The "primary" tier establishes social and behavioral expectations for the entire school, including staff members. "Secondary" interventions target groups or specific settings, while "tertiary" interventions focus on the needs of individuals and make use of individualized behavior support plans. Implementation of a PBS program creates an environment where rules and expectations are clear and consistent, are understood and accepted by everyone in the school, and are consistently enforced(Miller,

George, & Fogt, 2005). While a comprehensive overview of the PBS approach is beyond the scope of this review, it should be noted that this approach has been shown to significantly reduce problem behaviors, disciplinary referrals, and suspensions(Lassen, Steele, & Sailor, 2006). Use of a PBS framework has also been correlated with improved math and reading scores(Lassen, Steele, & Sailor, 2006; Luiselli, Putnam, handler, & Feinberg, 2005), and greater student perception of school safety(Metzler, Biglan, Rusby, & Sprague, 2001).

Centennial School was not the first to implement a PBS approach (it used a program implemented in Oregon as a model), but it stands out as a powerful example for two reasons: (1) it showed very dramatic results; and (2) the population of the school consisted *entirely* of students deemed to have severe behavioral problems. In a few years, Centennial School went from having over 1,000 restraint incidents per year to having zero restraint incidents and zero "seclusionary time-outs" in the 1999-2000 school year (Miller, George, & Fogt, 2005). This was an astonishing achievement. Numbers of restraints per year has remained near zero, as well.

Federal Policy Support for PBS

PBS approaches had actually achieved "preferential status" at the federal policy level by 1997 (Amos, 2004) before Centennial School had implemented their changes. The 1997 reauthorization of IDEA stipulated that students receiving an individualized education plan (IEP) with a behavioral component (because the student's behavior may impede his/her learning or the learning of others) should first be given a functional behavior assessment (FBA). The FBA, (which looks for the antecedents to challenging behaviors, and the functions they serve for the child) is used to develop a behavioral intervention plan (BIP) in the IEP. The law required that IEP teams consider *positive* behavioral interventions when creating a BIP (Turnbull, Wilcox, & Stowe, 2000). Changes to IDEA in 2004 maintained this requirement for a FBA in the development of an IEP for individuals with behavioral problems and maintained the preferential status of positive behavioral supports.

The empirical evidence and federal policy support for PBS approaches have not yet resulted in widespread implementation of these programs. While IDEA 2004 maintained preferential status for PBS interventions, other protections for students in special education have eroded to some degree. To accommodate staff and administrator complaints about red tape, and perhaps in response to public support for "zero tolerance" policies relating to behavior problems, it has become easier for schools to remove students with serious behavioral issues or to shift the burden for proving the relationship between the student's behavior and their disability onto parents (Bazelon Center for Mental Health Law, 2003).

Nationwide, the situation on the ground for students in special education appears to have become the patchwork that some feared would develop in the mental health field regarding seclusion and restraint policies. Federal policy *guidelines* have resulted in widely varying (or nonexistent) regulations on seclusion and restraint use, and PBS implementation, from state to state. Ryan, Peterson, and Rozalski (2007) point out that recommendations for policy development and implementation regarding the use of seclusion and restraint in schools have been made for more than 35 years, without significant results. Recently renewed efforts at implementing changes

seem to have been largely in reaction to costly lawsuits brought by advocacy groups and parents of children subjected to these practices. A number of studies reviewed made reference to these cases of misuse and abuse of seclusion and restraint with students, some of which resulted in injuries or fatalities. As was pointed out earlier in this report, much remains unknown about the frequency and circumstances surrounding the use of seclusion and restraint in schools, despite repeated calls for more research.

State Policy Support for PBS

Recent studies aimed at reviewing state educational policies on the use of seclusion and time-outs indicate that many states still do not have such policies in place (Ryan & Peterson, 2004; Ryan, Peterson, & Rozalski, 2007). Some states that were identified as having policies did not appear to provide adequate oversight of the use of these procedures, or did not have policies that were sufficiently comprehensive. The authors of one study, while noting that their research was not exhaustive, and that they may have missed some existing policies, or policies in development, noted that the "difficulty in finding and obtaining these state policies suggests that they may not be readily available to school systems, and that school systems have not made the development of these policies a priority" (Ryan, Peterson, & Rozalski, 2007). Among the 24 states identified in this same study as having established policy or guidelines, the specifics of the policies were found to vary "significantly." Of note for the purposes of our study, Indiana was one of the states that the authors were unable to locate any policy information for.

A policy brief recently released by the Center for Evaluation and Education Policy, in conjunction with the Indiana Institute on Disability and Community, addresses the state of PBS program development across the states, and in Indiana in particular. The study notes that at present, "41 states have developed statewide initiatives to support large-scale implementation of school-wide PBS." This statewide support is important; as research has shown that individual schools require systemic, external supports to effectively execute PBS programs. Indiana's adoption of PBS approaches has been piecemeal, and is "not coordinated by a statewide initiative." The policy brief concludes that, given Indiana's struggles with high rates of expulsions and suspensions, "a statewide initiative to support large-scale implementation of School-wide Positive Behavioral Supports would provide the leadership and support to Indiana schools to help them move beyond reactive approaches and toward a preventative and proactive approach to discipline" (Washburn, Stowe, Cole, & Robinson, 2007).

Recommended Practices

Clearly, action is needed to close the gap in protection from unnecessary, non-emergency, seclusion, and restraint for young people with disabilities in public school settings. Models exist in the fields of mental health and education for the effective elimination, or near elimination, of these measures—measures which have been shown to be dangerous and potentially lethal, traumatic for all involved, ineffective in establishing lasting behavior change, and extremely costly in terms of potential litigation. One common factor found in the successful models mentioned earlier (Pennsylvania's hospital examples and Centennial School), and in school-wide PBS models, is leadership and commitment at the highest administrative levels. This includes establishment and support of clear policies.

Research and existing federal policy suggest that the best time to correct problem behaviors is before they occur. A statewide commitment to implementing PBS programs would be the first, best step to reducing or eliminating unnecessary seclusions and restraints and proactively dealing with problem behaviors. Additionally, a commitment to school-wide PBS approaches in Indiana schools would benefit more than those students potentially subject to seclusion or restraint (Washburn, Stowe, Cole, & Robinson, 2007). PBS approaches improve experiences and outcomes for students school-wide.

Given that there is no systemic commitment to PBS implementation in Indiana at this time, and that even with such support in place there may still be occasions when emergency seclusions or restraints may be necessary, there should at least be clear policies in place addressing how and when these procedures might be used, and what kinds of oversight and reporting should accompany them.

Effective policies and procedures will most likely be based on mental health care models, or will come from states that have developed comprehensive policies regarding seclusion, restraint, and time-outs. Many of the materials reviewed for this study made recommendations about policy and procedures, (while also noting that some advocacy groups are working to eliminate the procedures entirely). The following outlines some of these recommendations.

School-wide policy regarding the use of seclusion and restraint should identify them as procedures for emergency use only, when the safety of the student or others is in jeopardy. They should be used only after less restrictive procedures have failed. If anticipated as a possible need, the use of seclusion or restraint should also be part of a student's BIP and IEP. The procedures should only be carried out by specially trained personnel. All staff working with students with emotional or behavioral disorders should be trained in behavioral management that emphasizes crisis prevention and de-escalation, should receive annual refresher courses, and should be certified in CPR.

Seclusion and restraint should never be used to force student compliance, to inflict punishment, or as a matter of convenience for staff. Restraint should use the minimum necessary force to prevent injury, should not impair speaking or breathing, and should be discontinued as soon as possible. Students should also be carefully monitored during seclusions or restraints.

School districts should be required to have policies and procedures concerning the use of seclusion and restraint in place. These policies should also include reporting procedures for staff and administrators when emergency seclusion or restraint incidents occur, including procedures for communicating with parents. Careful records of seclusion and restraint use should be maintained as data available to teachers, administrators, and Departments of Education.

A final recommendation is that Departments of Education look for statewide alternatives to seclusion and restraint use, such as the PBS model outlined earlier, and provide guidance and standards for implementation.

It is our sincere hope that this report on the current state of policies addressing seclusion and restraint use in Indiana school districts will serve as an impetus for change. Policy development across the state is highly variable, and does not adequately address this serious issue. Ideally, the State of Indiana could provide guidance for school districts in establishing policies on seclusion and restraint, and could commit to a statewide implementation of Positive Behavioral Supports as other states have recently done. The costs for not establishing formal policies and procedures for dealing with emergency seclusion and restraint may be very high indeed. Lack of preparedness by school systems in other states has resulted in violations of constitutional rights, trauma, injuries, and even deaths. As with the proactive PBS approach to dealing with problem behaviors, it is our belief that the best time to respond to an emergency is before that emergency occurs.

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